

LYMPHOEDEMA SERVICE REFERRAL FORM – NON-CANCER RELATED
Private & Confidential

NB: BLS DOCUMENT FOR MANAGEMENT OF CELLULITIS, SECTION 2 RELATES TO RECURRENT CELLULITIS
DO NOT REFER PATIENTS WITH WOUNDS/ULCERS TO THE LYMPHOEDEMA CLINIC; REFER TO DN'S/PRACTICE NURSES OR TVN.

Patient Details			
Patient Name: Known as: Address: Post Code:			Tel No:
			Date of Birth:
			NHS No:
			Location of patient:
CONSULTANT:			Hospital No:
GP:			Is the GP aware of the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
GP Address:			GP Telephone Number:
Site of Oedema:	Duration of Oedema: (Referrals must be >3months duration)		
Does Oedema resolve overnight/with elevation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the Oedema responsive to diuretics? Yes <input type="checkbox"/> No <input type="checkbox"/>		
ABNORMAL SKIN <input type="checkbox"/> IMPAIRED FUNCTION <input type="checkbox"/> PAIN <input type="checkbox"/> LIMB WEEPING <input type="checkbox"/>	DATE DIAGNOSED:		
Mobility status Please state if wheelchair bound. Past Medical History:			
BMI If BMI > 40 Have you referred to weight management services? Yes <input type="checkbox"/> No <input type="checkbox"/> Weight:			
Summary of Weight Management intervention:			
Has there been a recent reduction in weight? Yes <input type="checkbox"/> No <input type="checkbox"/>			
NB: Lymphoedema can be secondary to obesity therefore referral is contra indicated and weight management will need to be addressed prior to referral.			
SOCIAL CIRCUMSTANCES Please do not refer if patient cannot safely apply/remove compression hosiery. Patient can apply <input type="checkbox"/> Patient has Carer that can apply <input type="checkbox"/>			

DETAILS OF REFERRING GP, CONSULTANT OR CLINICAL NURSE SPECIALIST		
Name of Referrer (Print)	Designation:	Date of referral:
Signature or Email address of Referrer	Contact Number:	

Please ensure patients are aware this information will be held on computer according to the General Data Protection Regulations and that our privacy notice is available on the Hospice Isle of Man website.

Does the patient agree to Hospice clinical staff accessing their GP and Hospital clinical record? Yes No

If no, is there any particular reason for this? Please state

Please fax completed referral form to FAX No. 01624 647460, or post to the Clinical Administrator, Hospice Isle of Man, Strang, Douglas IM4 4RP

Website: www.hospice.org.im (includes Health Professionals Guidance)